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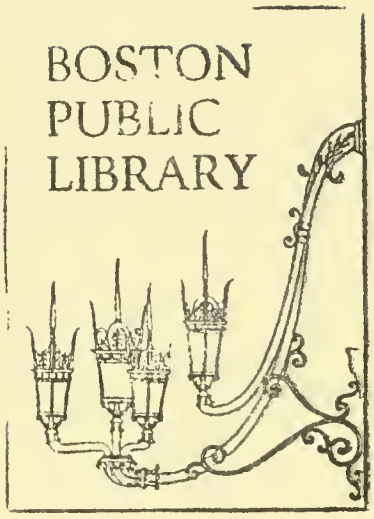

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THE UNATTACHED AND SOCIALLY ISOLATED RESIDENT ON SKID ROW

By

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I. INTRODUCTION

Every large and medium-large city in the United States has its Skid Row. Skid Row has come to denote a neighborhood in the city where there is a concentration of hotels and rooming houses charging very low rates and catering exclusively to homeless men with low incomes. These facilities are intermingled with numerous taverns, bars, restaurants serving low cost meals, second hand stores, missions that provide a free meal and lodging, barber schools, pawn shops, and stores selling men's work clothing.

Boston's primary Skid Row is located in the South End district in an area that is bounded by Northampton Street on the South, Broadway on the North, Tremont on the West, and Harrison Avenue on the East. Except for those people living directly in Skid Row areas or in areas marginal to Skid Row, the larger community, for the most part, prefers to ignore this section and its inhabitants. To be sure, most people have some stereotype of what Skid Row is like, and from time to time, as in the case of the Boston Traveler series in 1949, Skid Row is brought to the attention of the larger community (1).

The Traveler series demonstrates with remarkable clarity the strength of hard core areas and their inhabitants. The articles were interesting and colorful and yet aside from perpetrating the existing stereotype of Skid Row had no perceptible impact. Lacking follow-up, financial support and continued attention over an extended period of time all efforts are doomed to failure.

Although twelve years have passed since the Boston Traveler exposé, no real efforts have been made to create new arms of society and new supports to cope with the problem. Those agencies, such as the missions, who had been working with the problem continue to do so. As in the past, the homeless and socially isolated residents of Skid Row have been mainly handled by arrest and incarceration, and the passing around of these men from agency to agency, hospital to hospital, and institution to institution.

A new ingredient to the Skid Row problem has been added in the last few years, the factor of urban renewal and urban re-development. Since Skid Rows are run down and blighted areas, and since Skid Rows are generally located close to the central business districts of cities, they are among the first areas of a city to receive the attention of urban renewal authorities. Because of this new ingredient, the City of Boston like other cities throughout the nation, is again faced—among other problems—with the problem of what to do about the homeless men. Again, as in the past, an opportunity presents itself to directly confront the Skid Row problem and seek some reasonable, realistic, and humanitarian solutions.

In many ways, urban renewal in the Skid Row area will present a crisis for the different residents of that area. In a recent article, Duhl, quoting Justice Douglas, points out that in the Chinese, there are two characters for the word "crisis," one for danger and one for opportunity. It is our hope that the force of urban renewal will, through proper planning, enable the dangers and capitalize on the opportunity for finding a solution to the Skid Row problem.

Although there are many aspects to the human side of urban renewal on Skid Row, this paper will address itself to the problem of the homeless and socially isolated resident of Skid Row. This social problem group itself is highly variegated and although we will try to portray the total homeless man population, we will place special emphasis on that part of it composed by the alcoholic.

II. INVENTORY AND EVALUATION OF CURRENT PROBLEMS AND SERVICES

A. Dimensions of the Total Problem

During the last few years, rather extensive studies of Skid Row populations have been made in the Cities of Chicago (3), Philadelphia (4), and Sacramento (5). These studies were conducted by professionals hired by the cities to study the Skid Row problem as part of their urban renewal program and efforts.

In these studies, very careful evaluation was made of the populations residing on Skid Row. These findings indicated that there are many different types of residents of Skid Row. The data was secured from extensive interviews of the business men as well as the residents of the area, and included evaluation of such factors as housing, income, occupation, work ability, alcoholism, age, rentals paid, attitudes, etc.

In this paper we will not attempt to detail all of the factors found about the separate subgroups of the Skid Row population. Rather, we will outline the various kinds of subgroups and present a general description of them. In common to all of the groups which we will delineate are three factors as outlined in the Chicago study, (3). First, the men are "homeless," that is, they live outside private households, have no

family life, and have very transient, superficial and untrusting relationships with the other individuals they are in contact with. Second, they are poor. Many work only very irregularly and receive low rates of pay. They are at the bottom of the income scale. Third, they have acute personal problems and many are poorly adjusted in their interpersonal relations. Their maladjustment is predominately expressed in chronic alcoholism, in heavy daily drinking, and in withdrawal from conventional family living.

It would be incorrect to contend that every inhabitant of Skid Row possesses all three of these characteristics, just as it would be incorrect to contend that residents of other areas do not have any of these. But these three conditions seem simultaneously to afflict persons more frequently in this neighborhood of the city than in any other. Thus, Skid Row may be identified not only in terms of the kind of hotels, taverns, and other facilities found there, but also in terms of the unique type of social environment built upon this common social denominator.

It is a common stereotype of society at large that Skid Row is equated with the derelict, the bum, the chronic drunk. Each of the Skid Row studies (3,4,5) have found this stereotype, as in the case of all stereotypes, to have elements of truth, but to be basically erroneous. Who, then, is to be found on Skid Row? The following lists the subgroups in the Skid Row population and describes some of their characteristics.

1. <u>Elderly or physically disabled men.</u> This group is comprised of individuals retired or unable to work, who are

living on pensions, public assistance or private aid. They may drink but are not necessarily pathological or excessive drinkers. This group of men lives on Skid Row for many reasons: living accommodations can be found there cheaper than elsewhere in the city; older men can find companionship and relief from lonely old age; they are neglected persons and no one wants them; in some cases they are the last of their family line; some are social outcasts or unstable persons; some are heavy drinkers; some are on Skid Row because of employment convenience; and for some who are destitute elderly men, Skid Row is the last stop.

2. Resident working man. Included in this group of men are semi-settled or settled working men, either employed or employable, who are seeking work. Usually they work at unskilled or low-paying jobs. They reside in the Skid Row area permanently, although frequently they may change residence from one hotel or rooming house to another. They may drink but have not passed beyond the stage where they can no longer control their drinking. These men live on Skid Row because it is a center of employment for unskilled and daily laborers. Agencies, such as the Labor Pool, continually recruit men from this area. Also, for many it is almost the only place they can afford to live. For some, the social life on Skid Row is attractive; and for others, they live here because of the opportunity for drinking. Some working men are psychological and social misfits who are here because they are trying to escape from society. Some working men may live here because of the low standard of living and the lack of ambition to live any other way.

3. Migratory workers. This group is comprised of those individuals who come to the city between jobs, perhaps to spend the winter, or to find a temporary job before moving on to another place. They may drink but are not necessarily chronic alcoholics. These men live on Skid Row because when they first land in town they are in urgent need of services that only Skid Row provides easily. They can live there cheaply and find daily employment. Also, since Skid Row does not ask questions of strangers and has a great tolerance for anonymity, these men can move in and out without attracting too much attention.

4. "Bums" (Beggars and Panhandlers) There are two types in this group. One type might be considered the transient bum who just wanders from one place to another and makes a living by begging and seeking help from charitable organizations in preference to work. He stays in town for only a short time and may drink but not always to loss of control.

A second type in this category is the semi-settled or settled panhandler or other shiftless man who is physically able to work but who chooses not to work. This second type of man may be called a resident bum and is also likely to drink heavily but not necessarily always beyond the point of control. This man lives on Skid Row because it provides him with the maximum opportunity to get by with a minimum of work. He can also get help when needed from cohorts similar to himself For example, if he needs a drink, he will be allowed to participate in the "bottle gang."

The "bum" may also live on Skid Row because he expects and wants nothing better than Skid Row conditions. Still another important motive for residence in this area is that police "interference" is minimized. Although he is often found in the central business districts of our city and other places favorable for panhandling and begging, he is not welcome there, nor does he feel comfortable there.

5. Criminals and Workers in Illegal Enterprises. In this group are professional thieves, gamblers, pimps, confidence men, etc. These men may drink but they are not necessarily chronic alcoholics. Men in this category find easy victims on Skid Row for they can jackroll the drunk who is relatively defenseless. The jackroller is considered among the lowest of the low in the Skid Row status hierarchy. This group also engages and runs the petty rackets such as, the numbers game, placing small bets on horse races, and so forth. In this respect chief advantage is taken of the minority groups living on Skid Row.

This group of men also comes to Skid Row because it is a good place to hide from the police. For the most part, however, it is not the serious offender that hides out in Skid Row, but rather the petty thief.

6. Chronic Alcoholics. In this group are men who have passed beyond the excessive drinking stage and who cannot control their drinking enough to hold a job or to take care of themselves. These men are arrested repeatedly for drunkenness or disorderly conduct and spend a sizeable proportion of their time in jail or in other places for detaining drunks. This

subgroup itself is composed of subgroups of drinkers to be detailed later. These alcoholics are on Skid Row for a variety of reasons: they cannot afford to live elsewhere; they have been rejected by "normal" society; they have voluntarily withdrawn from society and are seeking to escape from reality. They find on Skid Row the tolerance, acceptance, and consideration, they can no longer find in the larger community, and Skid Row is the last hope of the down and out alcoholic.

These six groups form the major classification of the homeless men on Skid Row. It is by no means suggested that they are pure groups, for there is a great deal of overlap between some of the classifications. For example, there are many elderly and physically disabled men whose drinking habits are pathological just as there are many individuals in the resident, workingman and bum categories whose drinking is also pathological. By the same token there are many men in the chronic alcoholic category who are also elderly and physically disabled.

Other groups of men who are considered to exist on Skid Row include such categories as: runaways and adventurers who have left home because of quarrels, or left to see the world, landing on Skid Row without knowing exactly why;"vactioners" who are workingmen from other neighborhoods who are on a temporary binge; mentally unsound persons who are either feeble-minded or psychotic and find their way to Skid Row; sex perverts who can melt into the anonymity of Skid Row; and "normal" residents who are low income families and the businessmen or employees who operate or manage

hotels, restaurants, and other facilities on Skid Row and live in the area.

The percentage distribution of men in each of the classification categories described is not known. In the Chicago, Philadelphia, and Sacramento studies cited, the total population of homeless men is estimated to be from three to six thousand. It is a good guess that the size of Boston's homeless men population is within this same range. From other facts cited in these Skid Row studies (3,4,5), we can say that although drinking is pervasive and although the chronic alcoholic forms a large segment of the homeless men population, that equally large segments of men do not fall into these groupings. For example, in the Chicago study it was found that about 40% of the Skid Row residents are teetotalers or only light drinkers both by their own classification and reports of their drinking behavior. In the Philadelphia study it was estimated that about 35% of the Skid Row population are in the category of men with serious alcoholism difficulties. This finding with regard to drinking behavior supports the general conclusion that a substantial number of persons live in Skid Row areas for reasons other than drinking--such as the cheapness of living.

Some factors, generalizable to the total population of homeless men can also be cited. About 50% of the men are over 45 years of age and under 65. Another 17% of the men are 65 years of age and over. In other words, approximately 67% of the men are 45 years of age and older. About 60% of the men have grade school education or less. Another 33% of the men

have high school education or less and the remaining 31 have one or more years in college. This general educational achievement is below that of U.S. males in the United States.

It is also found that the vast majority of men have been reared in the city in whose Skid Row they live. Although the men are transient with regard to their life patterns, they are not transient in the sense of having migrated into the city because they were pushed out from other cities. All of the sections of a city are the breeders of Skid Row, both in the physical sense as well as in the sense of supplying its manpower. The Skid Row men do not reproduce themselves; rather, the men in the area are fed into it by the total city. Despite the growth of welfare and other economic protective devices in our society, most of the homeless men cannot manage to live beyond what appears to be a basic subsistence level.

Regarding family and friends, the data indicates that a large majority of the residents of Skid Row are without strong or effective family ties. Furthermore, these men perceive themselves as living in relative isolation from those in their immediate neighborhood.

With regard to employment, the data on Skid Row studies indicate that there is a sizeable minority of residents who live in object poverty. There is also another sizeable minority who have incomes that would make it possible to live somewhere else. Some persons may have had training in a skilled occupation at one time, but in most cases the residents' chief abilities are in the unskilled service and semi-skilled occupations.

The men show a high degree of chronic illness during their lifetime. Most of the conditions with which they have been afflicted are associated with advanced age and alcoholism. Despite this, the Skid Row men are not entirely helpless or apathetic regarding their self-care. Many of the men apparently seek and obtain medical care. On the other hand, the vast majority have not obtained help for chronic medical conditions, many of which might be relatively easily corrected or alleviated.

With regard to the men's attitudes about living on Skid Row, the majority of Skid Row residents do not perceive themselves to be part of Skid Row. They live there, they say, because it is cheap, relatively easy to find work, and convenient with respect to employment. They have superficial social relationships, but they prefer the impersonal touch for they really don't know whom to trust. Outside of their own circle, they view the rest of Skid Row in a way that a middle class visitor might; the other men are drinkers, shiftless, etc. Although they hold the middle class point of view to a limited degree, they behave differently; the inhibition and reluctance to share their thoughts with outsiders suggest that they are a group apart. The illusion of being better than most of the other men must offer some solace to their unpleasant reality.

Before turning to a more detailed description of the chronic alcoholic classification, we must again underscore the main finding of the studies of Skid Row. The composition of Skid Row is not homogeneous in all respects. It is composed of many subgroups for whom Skid Row serves different functions and different needs. In efforts to be made for relocation and rehabilitation of these men in the Skid Row areas, if anything is to be accomplished, it will be absolutely essential to recognize these different needs and to plan for them accordingly. As a matter of fact, one might generalize and say that there are two Skid Rows: one made up of the aged pensioner, the disabled, and the working man, whose problem is not one of excessive or pathological drinking; and, a second group made up of the non-addictive problem drinker and the more classic alcoholic who manifests complete loss of control. The management of the problem presented by the first Skid Row group might very well be made a part of general plans for the aged, for recreational and leisure facilities, and for other public health concerns. The chronic alcoholic group, on the other hand, will require special management unique to their own needs; and it is to this group which we now turn our attention in detail.

B. Dimensions Of The Chronic Alcoholic Problem

1. Epidemiology

As we have indicated in our previous discussion, the broad category of men on Skid Row can be grouped under the single label of the homeless, unattached man. Within this broad category, we have indicated a number of classifications, one of which has been designated as the chronic alcoholic. In the Chicago and Philadelphia studies, the size of this classification within the general grouping of homeless men has been estimated as approximately 35 to 45% of the total group.

It is likely that this percentage is also characteristic of the Boston Skid Row population. We do not know the exact number of men involved in this percentage distribution, but nevertheless by extrapolation, we can take a rough guess of the size of this population.

If we were able to stop the clock at around 11 pm on any night and take a census of the major institutions in which the chronic drunk can be found, we would have a rough idea of a minimum estimate of this population. The following is a list of the major institutions in which may be found the chronic homeless alcoholic. Alongside each institution is the typical, average daily census.

Charles Street Jail	135 men
Boston population at Mass. Correctional Institution, Bridgewater	300 men
City Prison of Boston	40 men
Deer Island	30 men
Rufus Dawes Hotel	200 men
Long Island Hospital	350 men

Boston population at Tewksbury Hospital	125 men
Boston City Hospital	100 men
Salvation Army	110 men
Missions	100 men

All together then, there are approximately 1500 Boston men in these institutions in any one night. About 500 of this group are under prison jurisdiction. However, if we add to this the hospitalized groups about 1000 of this total number might be considered in the category of a "captive" status. Since many more men live in rooming houses and hotels than in institutions (3,4) we have our first criteria for estimating the size of the population.

Another aspect of the epidemiology of the chronic drunkenness problem is where it is found area-wise. Again, we have no direct count but must rely on indirect arrest data for spotlighting those areas in Boston in which a serious drunkenness problem exists. To this end, the Boston Police Department (#6) has made available the arrest figures for drunkenness by police division headquarters. A map of the police division headquarters is included in the appendix. The following lists the number of drunkenness arrests in the highest ranking divisions for an 11 month period starting with June, 1960 and ending with April, 1961. There are about 22,000 male arrests for drunkenness in Boston each year.

Division Four	8037 arrests
Division Nine	2586 arrests
Division Six	1492 arrests
Division Ten	1330 arrests
Division Three	1118 arrests
Division Sixteen	1037 arrests

These 6 divisions comprise the major areas within the city with the highest arrest rates for drunkenness. There are arrests for drunkenness in all of the other police divisions as well, but for the 11 month period under discussion, each Division's total number of arrests is below 1000. Division Four has the largest number of arrests, but since it is located in the South End and covers the Skid Row area, this is not surprising. For the drunkenness arrest figures of the divisions listed, an examination of their location on a map of Boston will show that the predominant percentage of drunkenness arrests takes place in the core of the city.

It is interesting to note that the number of arrests in Division Three (located in the Scollay Square area) ranks high among all police divisions in arrest rates but is no higher than areas such as Roxbury, South Boston, and even the Back Bay. This in all likelihood reflects the fact that many of the residences in the Scollay Square area, which were previously available to the Skid Row man, are no longer available to him since the urban renewal efforts have started in this area. Although the men are still found in this area, especially since the Homeless Men's Service of the Boston Welfare Department is located in it, many no doubt have migrated down to the South End, increasing the South End Skid Row membership to an even greater extent than it was before.

These figures describe something of the gross size of the population of chronic drunkenness offenders, as well as their geographical distribution. We would estimate that Boston's homeless alcoholics total between 5,000 - 8,000 men. Although this knowledge is significant, it only provides a very small and passionless part of the portrait of the chronic drunkenness population, and it lumps all individuals together. We know however, through our own clinical observations and through many studies of this population,

that there are several subgroupings within the chronic drunkenness classification, to which we will now turn.

2. Types of Drinkers

As previously indicated, there are several subgroups within the pathological drinking population. The descriptions to follow are derived from our own clinical observations, as well as the research of Jackson and Connor (7), Peterson and Maxwell (8), and Rubington (9).

a. Older Alcoholics. This group of men tends to live in one place for a long period of time. They are known to either stick together with other men, or be social isolates. Many of these men are frequently on small pensions and are highly dependent on the landlords with whom they live. Sometimes these landlords will be the trustees of the older alcoholic's check, doling out money to him for drink, food, clothes, etc.

b. Winos. This group of men is identified not only because they habitually drink wine, with a consequently unpleasant, characteristic odor, but also by a generally rundown appearance (even by Skid Row standards) both in dress and physical condition. The wino has many associations with small groups of men. These associations, generally of three or four men, tend to be very informal and frequently of short duration, since their primary function is the procurement and consumption of wine. Sometimes this functional group is designated as a "bottle gang." Permanence is not a prevailing characteristic of these groups. The size and duration of a small group is often governed by the price of a bottle, the time it takes to raise this amount of money, and the time spent drinking it.

Winos have two main sources of money: work and panhandling. The wino may do short term and "spot" jobs, and work is undertaken with only one purpose in mind - to earn money for wine. The other method of obtaining money is to panhandle on the street or by approaching "live ones" (workers or others who have money) drinking in Skid Row bars. There is the risk of

being turned down by these "live ones" but often enough the winos succeed.

Within the wino group, there are two important roles - the "promoter" and the "runner." If between the group members they do not "hold" the price of a bottle, they will have to "promote" the difference. A man skillful in bumming money is known as a "promoter," and is sought out by groups. As soon as a group is "piecing out" a bottle, "the baby is born." Now comes the selection of a "runner" to be sent to buy the bottle. A great deal is at stake, by this time, and the runner must be selected with care. A person who is too dirty, too poorly dressed, or who shows obvious signs of intoxication is a poor risk, for he is likely to be picked up by the police. But of all considerations, the prime one is trustworthiness - someone who will not "go south" with the money or the bottle.

Winos help one another in obtaining some kind of sleeping arrangement, and in protecting each other from the police, and in times of illness. Winos have little respect for the majority of Skid Row missions and will exploit them frequently, a fact of which the missions are cognizant. The wino looks down on his fellow wino who hangs around the missions all the time. Such a person is a "mission stiff." Men guilty of violating the mores and taboos of the wino culture will be avoided by other winos - excluded from wino association. However, exclusion is not absolutely irreversible. All it takes for a man suddenly to regain a host of "friends" and an elevated status, is to come into some money and be willing to share it.

c. Rubbydubs or Dehorns. These individuals are habitual drinkers of non-beverage alcohol, chiefly bay rum and canned heat. These men may also resort to shaving lotion, paint thinner mixed with water ("smoke"), and rubbing alcohol. Most of the winos have drunk non-beverage alcohol at some

desperate moment or other, but the habitual user of such alcohol is considered to be the lowest of the low.

d. Lushes. This is the elite and prestige group of alcoholics on Skid Row. This group seems to be more organized, more protective of its members, and less likely to get arrested for intoxication than other Skid Row social groups. They maintain their distance from the other groups, although the line is often hard to draw between them and others. In general they may be in better physical and mental health than winos, rubbydubs, and older alcoholics. They adhere to the mores of Skid Row society but at the same time, they still carry with them the values of a middle class orientation. Many of these men consider themselves as being only in temporary residence on Skid Row.

Although the men in each of these groups are problem drinkers, distinctions beyond the different typologies can be made. Straus and McCarthy (10) in a study of the homeless men population on the Bowery of New York, say a substantial portion of these men should not be classified as addictive drinkers in the traditional sense. They define two categories of pathological drinkers - the non-addictive pathological drinker and the addictive drinker. The non-addictive drinker is defined as a person who is seeking relief from discomfort through the effects of alcoholic beverages. Only when striving for alcohol intoxication becomes insatiable and control over drinking is entirely lost is the classification of addictive drinking appropriate. Non-addictive pathological drinkers do not seek a maximum effect from alcohol. They are interested in the duration of their drinking rather than in intensity. They demonstrate foresight in allocating their meager available funds for alcoholic beverages in planning their drinking. They are also able to adapt their drinking practices, apparently without severe difficulty, to different periods of pay and to variations in their living conditions.

Probably the men in the lush category would be more like the addictive drinker whereas the men in the categories of the elderly and the winos would be in the non-addictive drinking category

The distinction made between the addictive and the non-addictive drinker may or may not be helpful from the point of view of classification for purposes of rehabilitation. The important consideration is that, although we may not describe the drinking habits of some of these men as addictive, we should not permit ourselves to believe that we are unconcerned with that proportion of the population of drinkers who are non-addictive, for it is an obvious fact that their drinking habits are pathological.

3. General clinical and sociological picture.

The information on which our general sketch of the alcoholic is derived is from many resources. (11, 12, 13, 14, 15)

Individuals vary with regard to their pattern of drinking, the manner in which they arrive on Skid Row, how they adjust to Skid Row life, their attitudes toward it, and the degree of anxiety felt in belonging to this subculture, but there are a number of social and individual characteristics or attributes which commonly exist in the pathological drinker on Skid Row. That is, there are some basic similarities in these residents.

In general the drunkenness offender fences off closeness with other human beings, and therefore, often lacks stable friendships and family relationships. Although the men seem to come from fairly stable homes, usually upper lower class, their own lives are marked by instability. They tend to move around a great deal and have a high separation and divorce rate. A good portion of the men have never married at all. No longer having any parents to turn to nor spouses to depend upon, these men flounder about without any attachment or social resources. To make matters worse, probably over 50% of them have some sort of physical handicap, usually minor but occasionally major.

The men have shown downward mobility from their primary occupational status. Whatever their earlier occupations, most of these people are employed at such marginal jobs as dishwashers, porters, laborers and temporary workers. Not only are these men employed in low status jobs, but their employment record is very spotty and irregular.

The men are on the average about age 50 and have not had education beyond the grade school level, though there are some men in the group who are high school educated and a few have had college education.

A considerable number of the men continually get into trouble with the police. It is not unusual for these men to have accumulated 40 to 50 arrests for drunkenness in their lifetime. Most of them started on their arrest cycle for drunkenness in their late twenties and their early thirties and have continued in this direction for ten, twenty or more years.

Insofar as individual attributes are concerned, these men are oriented to the present. They suffer a profound personality disturbance in which a key characteristic is their dependency in human relations. They are unable to give, they can only take from a supplier or protector. They are unusually regressed and primitive in their relations in the sense that they are interested mainly in satisfying their oral needs for food and alcohol. The men all show personality problems and almost invariably lend themselves to a variety of psychiatric diagnoses. A list of diagnoses covers the whole field of psychiatric illness. Many, if not most, of the men have suffered a great deal of psychological or actual deprivation in their formative years. Frequently they have been physically deprived of their mothers and fathers, or psychologically deprived because of an absence of a warm, giving, meaningful relationship.

Another common attribute of the men is their depression, which is most often expressed by a feeling of emptiness and loneliness. A very common way of coping with their life stresses is through denial, not only by their use of alcohol to the point of inebriety, but also in the general way in which they treat reality stresses.

Other attributes which have been said to exist in the underlying personality structure, as they are said to exist in the entire alcoholic population, are latent homosexuality, sadistic drives, self-destructive drives, rebellious feelings, and a deep lack of self-worth coupled with a feeling of inferiority.

A morbid past, a desperate present, and unfavorable prospects for the future are the characteristics of these chronic alcoholics. This grim impression of the Skid Row majority is unfortunately extended to the entire group. The individual is lost in the shuffle and this is a serious danger. It is our impression that at least 30% of the men we have described are potentially rehabilitable with the methods and facilities available today. With imaginative changes in the manner of treating them, and with a casting aside of the attitude that "they are all alike, just drunks and bums," it would not be unreasonable to hope that the lives of at least another 20% of these men can be salvaged. That is, a total of 50% are rehabilitable.

4. Types by Institutional Use

a. Chronic Drunkenness Offender.

As we have pointed out in other sections of this report, arrests for public drunkenness are common. This in no way is a reflection on the police, for they are merely acting as agents in carrying out the laws of the Commonwealth which reflect the collective views of society, and treat public inebriation as a misdemeanor or a criminal offense against society. Not all those arrested for drunkenness or incarcerated for drunkenness belong in the

Skid Row groups but many who are not would easily become residents of Skid Row.

In all of Massachusetts, there are approximately 65,000 arrests per year for drunkenness. Excluding motor vehicle violations, this category of arrests is by far in the lead of all other crime categories insofar as raw numbers are concerned. The same pattern holds in Boston (6,17,18) where there are approximately 24,000 to 25,000 arrests per year for drunkenness, of which approximately 2000 are females. Excluding motor vehicle violations, they comprise the largest number of arrests, more than all other crimes put together. Public intoxication is not only a frequent arrest category, it is also a frequent conviction category. More men are committed to Massachusetts Correctional Institutions for this one crime than all other crimes together. Police officers, judges, correctional officers, probation and parole officers have to deal with this problem in one way or another and it takes up a great deal of the valuable working time of these public servants.

Statistics (17, 18) show that approximately one-half of all those individuals arrested in the State and in Boston are released by probation officers. This is because any individual arrested for drunkenness can, at the discretion of the probation officer, be released anywhere up to three times in any single year without a court appearance. If they have more than three arrests in any year, they must make a court appearance, and these court appearances are made by approximately one-half of the number of men arrested. In the courts, their cases may be disposed of either through fines, a filing of the case, a suspended sentence, or a commitment to a jail, house of correction, or to the Massachusetts Correctional Institution at Bridgewater.

With the information now available, we do not know for certain the number of persons that comprise the total number of drunkenness arrests.

b. Indigent and Ill

By definition these patients are usually economically and medically indigent although a surprisingly large number will have some economic resources; pensions, old age assistance, old age survivors insurance, general relief, and assistance from family members. Many panhandle, many also work by the day for short periods of time.

In two Massachusetts studies of the homeless alcoholic medical data was secured and reported. In one (19) from a chronic disease hospital the authors report: "Although practically all of the cases have some medical diagnosis, in the main, the medical disabilities tend to be trivial. There is a small number of persons who have serious incapacitating disease as their sole problem, but this number is insignificant. The majority of them are serious social problems, with disease a relatively minor factor..... There are comparatively few insane and comparatively few feeble-minded, most of the insane being cases of senile dementia."

The other study of a general hospital emergency ward, as reported elsewhere in this report, found a variety of medical conditions, usually minor (20).

These patients traditionally present a variety of minor medical problems, many associated directly with their alcoholism. They frequently find it necessary to seek out medical assistance, often directly from a hospital. Many are also brought directly to emergency wards by the Boston police. It is likely that hospitals, and particularly emergency wards, which have a positive attitude toward the alcoholic are in an effective position to reach out to the patient by first meeting his medical needs. If this is seen by the hospital, as a first step in a continuous treatment relation the presenting medical condition can be a "blessing in diguise."

c. The Tuberculous Alcoholic In Massachusetts there are a number of patients with active tuberculosis who are either unwilling or, for a variety of reason, unable to cooperate with the normal regulations regarding the control of their disease. Any general statement about these persons and the problems they present would result in an oversimplified view of the situation, but for purposes of an epidemiological sketch, we divide this category of patients into the following groups (21):

Group A.

The patients in this group have resisted all overtures prior to the invocation of the recalcitrant law and an investigation by the Division of Tuberculosis Control, State Health Department. There is some suggestion that these patients have doubted the existence of a law providing for their compulsory hospitalization until confronted by it. In this group, an official visit overcomes the individual's resistance, and he accepts hospitalization without further pressure. These patients, generally, are able to exercise good judgment in the face of solid facts.

Group B.

The individuals in this group are often more belligerent than those in the preceding categories. Alcoholism is not uncommon as a complicating, additional illness. Family relationships are irregular and generally unstable, as are their employment histories. If the patient is a lone man living in a rooming house, he may have a history of several arrests for drunkenness. If he is married, he may have earned a poor reputation in his local community prior to contracting tuberculosis, and his family may be well known to welfare agencies.

It is usually necessary to apply the step-by-step provisions of the recalcitrant law in these cases; however, on arrival at the Treatment Center, they generally settle down after a day or two and become highly cooperative. They seem to achieve good understanding of their tuberculosis and, curiously, frequently become quite vocal advocates of the law which brought them there.

Group C.

This group presents the most frustrated experiences for all concerned. They may be biologically "poor specimens" or they may be mentally ill. Because of intellectual inadequacies or emotional malfunction, the individual is incompetent to exercise judgment in his own behalf, and usually needs social as well as medical intervention to protect himself and his community. Characteristically, it is almost impossible for him to respond positively to the companionship of others, and his past history is replete with conflict between himself and society.

The likelihood is that this type of patient has been hospitalized previously for tuberculosis, with a record of numerous admissions and departures against advice.

Medically and socially these individuals have arrived at the end of the line, and there are few, if any, alternatives beyond the locked ward for them. They are not good patients. They have lived largely on the fringes of society, and no amount of explanation will convince them that their enforced hospitalization is anything but imprisonment.

Cutting across the categories of alcoholism and recalcitrancy is that of the "homeless man". He is, to a much greater degree, a social problem than he is a tuberculosis problem. Their course of tuberculosis treatment is as irregular as the various facets of

their lives. If they enter a sanatorium, their durations of stay are as fitful and unpredictable as their behavior in other spheres of activity, and if their disease is temporarily controlled, the probability of relapse is much greater than among other patients.

They manifest, in brief, all of the social, emotional, economic, and motivational complexities of any negatively oriented group, with the added factor of having a communicable disease potentially dangerous to the community at large.

Because of their lack of stability in dealing with society, with the community, with their employers and co-workers, with their peer groups, with their families, with their disease, and with themselves, these persons represent a particularly difficult public health problem that cuts across all boundaries. Throughout the State as a whole, Greater Boston provides a clear statistical preponderance of these patients whose problems involve both state and local authorities in matters impinging on welfare, disability claims, settlement technicalities, etc.

d. The Emergency Ward Alcoholic While the population described below was drawn from only one Boston general hospital emergency ward (20) there is no reason to believe that the general characteristics vary much from hospital to hospital.

On the average, these men are middle-aged, predominantly Roman Catholic, either single, separated, or divorced. Slightly over half were employed at the time of emergency-ward admission, and over half were brought by the police. Few have medical insurance.

Nearly half enter the emergency ward with initial complaints centering around acute intoxication (inebriation, delirium tremens, collapse associated with excessive drinking); about a third, often acutely intoxicated, enter with fractures, facial lacerations and contusions; and the remaining one-fifth enter with a variety of other physical complaints, such as fever, coughing or stomach pain.

Twenty-five percent were homeless. i.e., without a place to sleep at the time of admission; over forty percent lived alone or in a variety of social institutions; and the remainder lived with relatives or friends. Thus, up to sixty-five percent might fall into the general category of an covered by this report.

In summary, the Emergency Ward alcoholic is middle-aged, usually without a family, frequently homeless or near homeless, typically unemployed and frequently involved with law enforcement agencies. They are largely destitute and without social resources.

c. <u>The Out-Patient Clinic Alcoholic</u> The typical out-patient clinic alcoholic is a male in five out of six cases. Coming from a large family, in which 30% of the parents (one or more) are also alcoholic, 30% will also have one or more alcoholic sibling.. Marrying at a rate about equal to the general population, they separate and divorce at a considerably higher rate. For those still married the female alcoholic has an alcoholic spouse in 45% of the cases; the male alcoholic patient has an alcoholic spouse in 9% of the cases

At an average age of 40, they are bearing children at a lower rate than the general population.

Their education is typical for the general population of their age and sex.

Almost 75% admit to an arrest, usually for drunkenness or automobile violations.

Sixty percent will have been employed at the time of admission to the clinic with some general evidence of downward occupational mobility.

In general most of the out-patient clinic alcoholics represent the American middle class.

5. Description of Existing Services

A. In-patient Programs

a. LONG ISLAND HOSPITAL

Sponsor. The Long Island Hospital is a part of the City Hospital Department comprised of the Boston City Hospital, Boston Sanatorium* for the treatment of Tuberculosis, and Long Island Hospital.

Plant. Long Island Hospital is comprised of two sections, a chronic hospital section for the treatment of chronic illness and a dormitory section for homeless men. The dormitory section, which is used by the patients of the Long Island Hospital Rehabilitation Program, consists of a three story building with showers and wash-room facilities on all floors and sleeping facilities for approximately 140 men on each floor. In addition, the Program ward also has a special room for the clothing of the individuals who are employed and the sleeping quarters for the ward master who has volunteered to supervise the ward cleaning, changing of linen, and so forth, and is also a patient.

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* As a consequence of recent legislation the Sanatorium will soon be transferred to the State Department of Public Health.

Facilities. The regular hospital facilities used for the treatment of chronic illness, Out-Patient Department, X-ray Therapy, Medical staff, Nursing Staff, and so forth, are also available for the treatment of alcoholics. A special ward, of 20 beds, is available for the treatment of acute withdrawal symptoms.

Purpose. The purpose of the Program has been to break the cycle of many of the patients who are products of a skid row environment, excessive drinking, working in a menial type position, where he is paid by the day, existing on a substandard diet, eventual hospitalization, or arrest, and eventual incarceration in a correctional institution. After his release from the correctional institution or hospital, without funds, his inability to cope with the many problems confronting him due to the inadequacy of his diet, lack of funds and decent employment opportunities, he returns to his old environment, a problem to the community.

Referral. Referrals by the courts are made for individuals who in the opinion of the presiding justice may benefit from treatment and who express a desire to become part of the Program. Referrals are also received from Clergy, Probation Officers, Courts, private agencies, Correctional Institutions, and Alcoholics Anonymous members.

Admission. Admission to Long Island Hospital, dormitory section, is on a voluntary basis. Patients must be Boston settled cases, and not over age 65. Those who desire to be admitted to the Long Island Hospital dormitory section apply at the admission office located in the center of Boston each morning Monday through Friday and are transported in special beach wagons provided for this purpose.

All persons applying for admission are given a physical examination at the admission office. After arrival at Long Island Hospital, patients are given a complete physical examination, x-ray, medication in the Out-Patient department and if necessary, transferred to a special ward for withdrawal purposes. After a period of 7 days, if physically fit, the patient can then apply voluntarily for rehabilitation and treatment for alcoholism.

Treatment. At the present time there are approximately 20 male patients who are seeing the psychiatrist, approximately 15 who are seeking employment and 40 who are employed and working from Long Island Hospital. Approximately 5 new patients are accepted each week and another 5 will be released to seek employment. The female Program is much smaller comprising 5 individuals at the present time, two who are employed. In addition to the treatment facilities available at the hospital, clergymen of all faiths participate in the effort to rehabilitate patients. Alcoholics Anonymous plays an important role with both an open and closed meeting at the hospital twice weekly and by taking selected patients to outside group meetings to give them a better opportunity to observe and understand their problems in a non-institutional environment. Efforts to re-establish contact with their families, when advisable, are made by Social Service personnel prior to their discharge.

The program itself is quite simple. Upon admission to the program the patient is helped to find a job in the community while residing at the hospital for an extended period of time. For the first six months they pay $10.00 a month room and board, increased to $15.00 a month after that. The average stay is 5 months with no specific maximum.

In conjunction with this work program, casework, psychiatric support, AA, and religious counselling are offered.

Personnel. The staff consists of 2 Psychiatric Consultants (1 for the female and the other for the male Program), a Head Social Work Supervisor, 3 Social Workers, 2 Senior Clerk Stenographers, and a Principal Hospital Medical Worker, all of whom work in the Alcoholic Rehabilitation Program in addition to their other hospital duties.

Follow-up. Follow-up care of discharged patients is accomplished through the Out-Patient Department which meets once every two weeks with the psychiatrist in the evening at the admission office at 25 Church Street. Patients are notified of these meetings by mail. This clinic is also used for employed patients residing in the hospital.

Census. In a population of approximately 350 patients who are housed in the dormitory section, about 125 are part of the alcoholic program. Approximately 100 patients in this other group would be over age 55 which is the maximum age for a member of the Program with exceptions. The remainder of this group is comprised of men who have been members of this Program on previous occasions and waiting to apply at some future date due to a variety of reasons, minor illness, and so forth.

Evaluation. Individual research by psychiatrists associated with the Program has disclosed that approximately 50% of the patients have been assisted in various ways. Some have been able to retain sobriety since first becoming members of the Program over 8 years ago and are now employed and living in the community as useful, productive citizens. Others have been successful for lesser periods and have continued their treatment after a relapse over a period of years.

There are no restrictions as to the number of times a patient may apply for the Program. The emphasis is placed on the willingness and sincerity of the patient to respond to the treatment and help himself to sobriety.

Urban Renewal Implications. The Superintendent sees in urban renewal a possibility for securing additional funds. He hopes that the community will recognize the need for broader based support.

Specific Needs. The newest building is now 30 years old, the kitchen and bathing facilities are limited -- general renovation is needed.

While satisfied with the present program he would like additional therapeutic personnel. For example, more psychiatric time is needed. He could use effectively a psychologist and recreational therapist. In addition although budgeted for an occupational therapist the salary scale is so low he cannot fill the position. This needs improvement.

b. BOSTON CITY HOSPITAL

Census. This general hospital, serving as a major training center for Boston's three medical schools, has 131,000 emergency ward admissions, and 30,000 plus admissions to the house each year. Out-patient visit data was not secured. On any single day about 360 patients will be seen in the emergency ward(about 100 of whom will be admitted to the Hospital) and 950 individuals will be in-patients.

Alcoholics. Between 30-40 emergency ward patients each day (10%) will fit our "Homeless Man" category. An estimate of "Homeless" in-patients is impossible but somewhere between 20-30% of all admissions have a primary diagnosis of alcoholism.

Impact of Urban Renewal. It is likely that the character of admissions will change as it has through the years with the changing composition of Boston and the area in which the Hospital is located.

Possible Role of Hospital. That the Hospital should serve as a major screening and diagnostic center for "Homeless Alcoholics" is seen as appropriate. In order to accomplish this, it would be necessary to construct a small 30 bed unit near the admitting area since the existing facilities are already overcrowded. In addition, staff, particularly additional social workers would be needed. Collaboration with the existing State Health Department, Boston City Hospital Alcoholism Clinic would add out-patient treatment personnel to the unit.

c. WASHINGTONIAN HOSPITAL

Sponsorship. This private 60 bed hospital specializes in alcoholism and drug addiction. Financial support comes from endowment, special gifts and the United Community Services.

In-patient Facility. With no more than 4-6 beds per room, the hospital is divided into three locked wards; an acute ward for men and women, a sub-acute ward for men and a sub-acute ward for women. Recreational facilities are available.

Staff. Physicians, (including psychiatrists), nurses and attendants.

Treatment. Medical treatment, psychotherapy, casework, group therapy, conditional reflex treatment, drug therapy and night hospitalization plan.

Census. Ordinarily between 40-50 patients will be hospitalized at any one time, a very small number of whom will be "Homeless". Total number of in-patients during the year is 1265.

Admissions. Beds are ordinarily available immediately for patients with financial capacity ($120-$130 per week).

Indigent patients can be admitted in limited numbers between 9:00A.M. - 5:00 P.M., Monday-Friday and are financed by the Hospital or by the Division of Alcoholism, State Department of Health.

Out-patient Clinic. An out-patient clinic supported by the Division of Alcoholism, State Health Department is operated in the Hospital. Referrals are made both from those admitted as in-patients and directly from the community.

Urban Renewal Implications. The potential maximum bed capacity for this institution has not been developed. With adequate financing 75 beds would be available. If in-patient hospitalization could be financed part of the needed facilities could be found here.

d. TEWKSBURY STATE HOSPITAL

Location. Tewksbury, Massachusetts

Sponsor. State Department of Public Health

History. This state institution, planned in 1854, was established as an almshouse for the unsettled poor (those without legal residence in a specific community.) Since that time the institution has gradually moved toward the medical classification for the unsettled poor with chronic diseases. Only in the last decade, however, was it transferred from Public Welfare to Public Health auspice.

Census. The total census is usually about 2,000, with about 5,000 admissions per year.

The most recent comprehensive study of admissions was in 1948. At that time the major primary diagnosis (37%) for male admissions was alcoholism. Regardless of diagnosis about 2/3 of all male

admissions were chronic alcoholics. The typical patient then was described (19): "These persons have not done well in school. They have gotten along poorly in industry or their jobs, there being very few who have worked steadily for long periods of time or have acquired great skill. If they have married, the marriage tends to end in disaster, and many express an utter indifference as to the whereabouts of wife or children. Most of them were problem drinkers at the age of 30. They start coming to Tewksbury along in mid-life, primarily because they are down and out, and the immediate cause of this is often alcohol, or less frequently, some physical disease."

In 1961 the picture has changed only in degree. Although the institution still receives many alcoholics the number of admissions from other diagnostic categories is increasing, alcoholics decreasing.

Staff. The staffing pattern is traditional: physicians, nurses, attendants and social workers with psychiatric consultation. About one-half of the medical positions are unfilled.

Program. Except for a handful of patients (about ten at a time) there is no special treatment program for the alcoholics. For this group a special program allows patients to work in the community and return to the institution for a two week period prior to discharge.

Admissions. In Boston referrals can be made at 25 Church Street (operated by Long Island Hospital) for patients not settled in Boston.

Impact of Urban Renewal. If visibility increases and the homeless men of Boston are forced into institutions, Tewksbury State Hospital will receive its usual share and is prepared to admit them.

Plans. The Superintendent has expressed his willingness to participate in any overall plan which is developed.

e. STATE MENTAL HOSPITALS

Sponsor. State Department of Mental Health

Location. In Boston - The Massachusetts Mental Health Center and the Boston State Hospital.

In Suburban Boston - The Metropolitan State Hospital in Waltham.

Census. Although exact figures are not available, it appears, based on small studies in four different Massachusetts State Hospitals and the estimate of the Commissioner, that about one-third of all admissions will have a primary or secondary diagnosis of alcoholism. No estimate can be made of the number who are "Homeless," but it is substantial.

Treatment Program. No special treatment program for alcoholics exists in any of the above three hospitals, instead they are handled as all other admissions.

Admission. There are a number of admission procedures to state mental hospitals, some of which can also be used for alcoholics. Special admission procedures for alcoholics can also be used at the discretion of the Superintendent.

Impact of Urban Renewal. If the consequence of urban renewal is to precipitate movement of homeless men around the city it is likely that both commitments and voluntary admissions will increase.

Plans. As with all other institutions any active new program depends upon available staff. Since these hospitals are overcrowded and understaffed assistance must be given before any major change will occur. On a policy basis the Department has continually expressed its willingness to cooperate in any total alcoholism control program.

f. MISSIONS

1. Boston Industrial Home - Rufus Dawes Hotel

Physical Plant. This facility is located in the South End, directly across Warrenton Street and off Washington Street. The building has a main floor, a basement, and two other floors. In the basement there are shower facilities as well as facilities for delousing and smoking. There is also a planned kitchen area which has not as yet been fully activated.

On the first floor is a general, large lobby area where the men can sit around, talk, and read old magazines. This is also the area from which they are admitted. The Superintendent's office is located on this floor as well. There is also a large, attractive chapel, at which services are held three evenings a week during the year, (one evening a week during the summer months). Another room has X-ray facilities for tuberculosis case finding, where counselling is done as well.

On the second floor is a large loft-like area in which there are 125 individual cot beds. There are no individual rooms on this floor. On the third floor are 70 beds at the present time, used in dormitory fashion. However, plans are afoot to develop this area into individual single rooms, as well as a place for recreation and reading facilities. A dozen of these individual rooms have been built recently. Six more rooms are older and already exist. Another dozen rooms are planned. These new plans will, after renovation, make for a net loss of about 40 beds.

Admission. The doors open for admission at 7:00 P.M. and close at 10:30 P.M. The men have to be out by 7:00 in the morning. At present they are supplied with coffee and doughnuts in the morning, if they wish. They get to their beds through use of "an usher" with a flashlight in movie fashion, since otherwise some of the sleeping men would be disturbed.

Sponsorship. This is a church-sponsored institution, with a Board of Directors, that was built in 1916. The Board of Directors represent various church groups, but the main support is from the Congregational, Baptist, and Presbyterian churches, mainly the former two. The institution is also affiliated with a group called the International Union of Gospel Missions.

Personnel. Mr. Reuell, the Superintendent, is full-time and he has two assistants, one part-time, one full-time. In addition, a number of men are used for custodial and general help. There are bed squads and some other general assistants. These men get paid very minor sums for their services, but do get their meals and lodging. Presumably, they are the rehabilitation program at this time. The lack of personnel is one of the main problems of the institution.

Census and Charges. Men come to Rufus Dawes each night on a first come, first served basis. During the year 1960, they had 70,000 admissions, but we have no idea as to the number of people involved, since they are unable to keep records. Their charge for the bed is 50¢ a night. The Department of Welfare in the City of Boston pays for many of these men each night. They are also referred from other missions and other places. Only a negligible number,

probably less than 5, do not pay. Mr. Reuell claims that this is the only hotel in Boston of its kind. At the present time, cleaning up at night is not compulsory, but as soon as they develop their shower system, this will be a compulsory part of the institution.

General Comments. The men are referred to the Labor Pool Agency, Manpower, Inc., and restaurant chains for jobs. This is mostly part-time work and day work. At this time of year, they also get summer camp requests. Mr. Reuell estimates that from 25% to 35% of his population are in a true transient class, that is, migrating from other cities within Massachusetts as well as from other states. The transient group itself consists of two kinds, those who are down on funds but looking for a job, and others who are "liquored up" and not really interested in working.

Minority Groups. One particular group serviced by the institution is the Mic-Mac Indians, who come from Maine, New Brunswick, and Nova Scotia. They try to keep the number of these Indians down at any one time at the institution because they tend to be in an in-group, and have potential for causing trouble. Also, each night they have from 12 to 15 negro people. Like the Mic-Mac Indians, they too tend to stick together.

Age. Although five to ten years ago, in the 1950's, the average age of the population seemed to be in the 50's, Mr. Reuell feels that the average age appears to be going down, and that the people nowadays tend to be in the 40's on the average, and that there are also more and more individuals in the 25 - 35 age bracket. In this younger group, they are virtually all alcoholics.

Tuberculosis Control. Every Monday night they have an X-ray program under the sponsorship of the State Department of Public Health. A list of those individuals who are diagnosed as having tuberculosis is left with Mr. Reuell, as well as with Mr. McGonigle of the Boston City Welfare Department.

Relationships. Rufus Dawes has recently merged with the Union Rescue Mission, which itself handles from 12 to 15 men whom they keep in a rehabilitation program.

In general they have very good relationships with the police, who sometimes bring some men to them. He says they try not to bother the police too much, except when they really need them, expecially in the case of medical attention for some men. Because of this, the police know when they are called by Rufus Dawes that they are really needed, and are not just being pestered.

Rehabilitation Program. At the present time, there is very little programing for the men. However, plans are being made for a program for 30 men. This program will include a daily bible class in which there will be no proselytizing from one Christian faith to another, but where an effort is made to have a man gain faith in Jesus Christ. A large percentage of the men at the institution are Catholic. They also hope to have more personal counselling of the men, from which they will evaluate their attitudes about a variety of things from time to time. The men will work around the building and will be paid only small amounts of money for their personal needs. The plan is for the men to stay for a three-month period, at the end of which time plans would be made for weaning them from the institution.

Opportunities and Planning. Mr. Reuell feels that the ideal plan for the homeless man exists in Detroit, where they have an institution 15 to 20 miles out of the center of the city. It is a rehabilitation center with medical facilities, counsellors, with a kitchen and a work program. They do a lot of work like printing, furniture refinishing, etc., and are supposed to be self-supporting. Mr. Reuell would like something like this, perhaps on a farm as well, in the future. He also mentioned that he had in mind a relocation area for a facility, like Detroit's in the Army Camp on Long Island.

2. OTHER MISSIONS

Introduction. Because the Boston Industrial Home--Rufus Dawes Hotel is not only larger than all other missions combined but is in general typical, it has been described in great detail. Following are brief descriptions of some of the other "mission" facilities available for the homeless men.

Bethel Christian Centre, 332 Hanover Street, Boston
Open 9 a.m.-12 noon through Friday and Saturday. The menu is soup, sandwiches and coffee. Provides clothing during winter months. No fee.

Calvary Mission, 15 Cornhill Street, Boston
Provides food, clothing, and pastoral counseling for males only. No fee.

Merrimac Mission, 107 Stanford Street, Boston
Provides food, clothing, lodging, and pastoral counseling for homeless alcoholics. No fee.

St. Francis Refuge, 470 Albany Street, Boston
Open 11-1 p.m. daily. The Refuge serves substantial meals free; no questions asked. The menu is usually thick vegetable soup, rolls, coffee, doughnuts, etc. No fee.

St. Vincent DePaul Society, 7 Water Street, Boston
Provides food and clothing for alcoholics in need. Pastoral counseling available. No fee.

St. Vincent DePaul, 1280 Washington Street, Boston
Provides temporary and permanent employment on a "sheltered" basis. Temporary employment is of "work" relief variety in which men earn money for a nights lodging, clothing, food or transportation.

Scandinavian Seamen's Mission, Inc., 287 Hanover Street, Boston
Accepts persons whose immediate problem is alcoholism. Men only. No fee.

Union Rescue Mission, 1 Dover Street, Boston
Provides food and clothing for indigent persons. Lodging available for alcoholics interested in rehabilitation. Pastoral counseling. No fee.

Other: The Twelfth Step House, 23-25 Dover Street, Boston
Although not a mission this day care center operated by recovered alcoholics (members of A.A.) is also in the Skid Row section of Boston. By providing these indigent men with a non-alcoholic, non-punitive environment (with help available) during the day, the Twelfth Step House is meeting a real need. No fee.

B. OUTPATIENT PROGRAMS

Location: Boston City Hospital; Massachusetts General Hospital; New England Hospital; Peter Bent Brigham Hospital; Washingtonian Hospital.

Sponsor: The Division of Alcoholism--State Department of Public Health, and the individual hospitals.

Staff: The basic staff of the alcoholism clinic consists of a physician-in-charge, a psychiatrist in all of the five clinics listed above; a specialist in internal medicine; a psychologist; one or more full-time social workers and full-time secretarial assistance. Ordinarily the physicians and psychologists are part-time employees.

Relation with Hospital: With the exception of the Washingtonian Hospital all of the state supported alcoholism clinics (15 of 16) are located in general hospitals. This means that the entire facalities of the hospital are available to the alcoholic patients for both diagnosis and treatment.

Census: In 1960, 972 patients were seen in the five Boston clinics; 885 of these being new admissions. Only a minority of these patients are of the homeless man category, probably less than 20% of all admissions.

Admission: Clinics are open weekdays 9 a.m. to 5 p.m. and occasionally some nights and Saturdays. Referrals can be made by anyone, including the patient. A telephone call is recommended.

Treatment Regime: How does an alcoholism clinic actually operate? The succeeding paragraphs, taken from a leaflet describing one clinic is typical. (27)

"First, there is what is called an initial contact. This is where the clinic first meets with the patient; and therefore, such basic information as address, telephone, relatives, employment status, and the like are listed for the clinic records. Secondly, an appointment is made for the patient to have an intake interview with one of three psychiatric social workers on the staff. In this meeting, the social worker and the patient talk together with the purpose of helping the staff obtain a reasonably complete picture of the patient's alcoholism problem as it affects his home, work, and social relationships. When appropriate, other family members are interviewed.

"Concurrently, the patient undergoes a complete physical examination conducted by the medical director. Following the initial contact, the intake interview, and the physical examination, the entire staff discusses at its weekly staff conference how the clinic might best help the patient. In the meantime, the full resources of the hospital's medical facilities are utilized to treat the patient's physical problems. Under the supervision of the medical director, treatment and necessary medications are arranged for such problems as dietary deficiencies, liver disease, and other conditions sometimes associated with alcoholism. When necessary, sedation is prescribed, and Antabuse is used on occasion along with the clinic's other treatment procedures so as to treat the patient as a whole, physically and mentally.

"At the weekly conference, the staff decides from among several alternatives on what is thought to fit best the patient's needs. The choices are as follows: (1) that the patient could benefit from the treatment which the clinic offers, or (2) that he

would receive treatment more appropriate to his condition by referral to another agency, or (3) further evaluation of the patient by the psychiatrist and, on occasion, by the psychologist. When the recommendation is made that the patient should come to the clinic on a regular treatment basis, the staff decides which of its members should work with the patient. Similarly, when it is felt that the patient would benefit more through referral to another agency, the staff acts on its decision by arranging to bring the patient and agency together. In summary, the patient and the staff share mutual obligations. The staff accepts the responsibility of arriving at a treatment plan or referral. The patient is responsible for giving serious consideration to recommendations and for carrying these out if he wants to bring about a change in his alcoholism. Fees are scaled to that which the patient can afford."

As a rule the clinics do not do well with the homeless alcoholic. Few of these patients have sufficient ego strength, community and familial ties, and economic and employment stability to effectively utilize outpatient form of therapy by itself. In our recommendations we suggest procedures whereby the alcoholism clinics could be utilized more effectively.

Fees: A small fee is charged patients with ability to pay, for those unable to pay the charge is waived.

Impact of Urban Renewal: As with most other agencies dealing with large numbers of alcoholics it is likely that many more homeless alcoholics will be referred to the outpatient clinics.

Plans: The outpatient clinic by definition has certain strengths and weaknesses. Until some of the community gaps are filled, it will not be possible to make maximum use of their special knowledge, training, and skill in dealing with the homeless alcoholic. They stand ready, however, to help in the planning and to actively participate in any new program.

Special Project: The clinic at the Massachusetts General Hospital is now engaged in a research project in its Emergency Ward. As such it has developed special skills which will be useful in any new program.

C. SHELTER PROGRAMS

a. THE SALVATION ARMY

Location: The Salvation Army has a work shelter program for men who live in at their center located on Brookline Avenue, Boston, across from Fenway Park. The Salvation Army Center is administered by Brigadier Richard E. Baggs.

Census: The Center is a modern facility containing room for housing 148 men. At the present time the number of men housed there and working on a work shelter program is about 100 to 110.

The Program: Before a man is accepted to the program he has to be relatively sober if not absolutely sober. If admitted, they are expected to stay with the sheltered workshop program for two to three months. They receive a physical evaluation when they enter the program and are then given a bed in one of the small dormitories and a work assignment. Each morning the men in the building participating in the salvage of the many materials which the Salvation Army collects. He may work in the electrical

repair shop, the upholstry department, carpentry shop, baling department, etc. He has his meals in a large central dining room.

Available to the men during evening hours is a large lounge where they can sit around and read, smoke, or talk. Also available close to this lounge are a library and a recreational area consisting of television and billiard tables.

Transition Steps: Built into the program is a reward system. With increasing responsibility and sobriety the men are encouraged to graduate from a six or eight man ward to a single room. If successful in the two to three months program, he may then be housed in a separate section of the building with his own room and work as an employee of the Salvation Army. The next step is to graduate from the Center and to find a position in the community. At this point the man will work in the community but still live in the Center in his own private room. Now he is expected to pay for his room and board. When the man is in this stage, he has already moved from a sheltered work shop program to a half-way house program. The final step is to move the man out into the community where he is working competetively and living on his own.

Chapel: Chapel facilities are available to the men with religious services conducted on a regular basis.

Cost: The annual cost of operating this in-patient program and a work shelter program is approximately $400,000 of which $370,000 is taken care of by the work of the men in the salvage program.

Plans: The Salvation Army, in recognition of the fact that the homeless man is moving down from Dover Street, along Washington Avenue, toward Blackstone Square and the Blackstone Park, has purchased a building in the Blackstone Square area. A 10 bed drying-out center will be opened on a twenty-four hour basis with nursing care and medical consultation. Beside the 10 bed drying-out service there will be an additional fifteen to twenty rooms. The plan is to start the man on his rehabilitation trail at this center, dry him out, and to prepare him for the work shelter program. When he is ready, he will be then taken to the headquarters on Brookline Avenue and start with the program there.

Relation to Urban Renewal: Brigadier Baggs made very clear his willingness to participate in any planning program and to cooperate in any plans resulting from this program.

b. Morgan Memorial Goodwill Industries

Location: 85 Shawmut Avenue, Boston, Massachusetts

Sponsor: Morgan Memorial

Plant. The Morgan Memorial has sheltered workshops, about 20 departments in all. Types of jobs range from skilled to unskilled, e.g., receiving and shipping, bag opening, rough sorting, textile work, small ware repair, furniture repair, metal salvage and baling.

Facilities. The Goodwill Industries program is essentially divided into two parts: the first employs about 350 people/day, average length of stay one year to 17 years. These people, 60% male, 40% female, are all handicapped and are being trained for competitive outside work. Perhaps half have had a diagnosis of alcoholism usually associated with other problems.

The second program is a daily work relief plan for 60 men (clients) who work for meals, clothing, and a "flop." Usual pay is $4.00/day. The availability of these jobs depends on the season. In the winter it might be necessary to turn away 20 a day. Individuals under the influence or possible insurance risks will not be accepted. An attempt is made through casework to get these people on a weekly payroll. Over half will have left the program by the end of a month. Average range of stay, one day to one year. Most alcoholics are referred to the Homeless Mens Service on Church Street. The total number of employees and clients during the year will be about 2000 plus, half or more alcoholic. Patients do not live on the premises. The majority live within walking distance of Morgan Memorial.

Admission. The patient should present himself at Shawmut Avenue. Referral preferable.

Financing. All money received from sale of articles (in 15 Massachusetts retail stores) is returned as wages. Salvage sale money is used for overhead.

Staffing. The personnel director is a psychiatric social worker who sees her major job with alcoholics as referral through casework.

Urban Renewal Implications. The Director feels that his agency should "try to discover what it can do best as a private agency." One immediate result is that the plans for the new toll road will necessitate the demolition of some of the present plant. As such, plans are now underway to construct a new 2½ million dollar building with expanded facilities for training (750-1000 people/day.) Thus he sees urban renewal plans as an impetus for his agency to make new plans for the future.

Other Programs. Nine other programs, expending $300,000 of the total $1,600,00 budget have not been described since they do not ordinarily deal with alcoholics.

D. Half-Way Houses.

This type of facility, as the name implies, is a facility which bridges the gap between one way of life and another, for example, penal and other large institutions and the community.

Serving Boston alcoholics are three half-way houses: Long Island Hospital, Washingtonian Hospital, and the Boston Sanatorium. There are a variety of programs in each of these institutions and included are half-way house programs.

The half-way house program in the Long Island Hospital was described in a preceding section. The Washingtonian Hospital permits some of their patients to work in the community during the day and return in the evening. The Boston Sanatorium has a half-way house program for the tuberculous alcoholic. This program,started within the last year, has as yet serviced relatively few patients. They have the potential for running a program for 35 men at a time.

E. Emergency Ward Programs.

Although all of the general hospitals see many alcoholics in their emergency wards, only the Massachusetts General Hospital operates a special treatment program for selected alcoholics.

Typically patients are treated for their presenting medical condition and then discharged. Where an alcoholism clinic exists in the Hospital, a referral might also be made to it. Study shows that a negligible number follow through their initial hospital contact by presenting themselves for treatment of alcoholism at the outpatient clinic.

The thesis of the Massachusetts General Hospital team, is that constructive utilization of the alcoholic's needs when he enters the emergency ward of a metropolitan general hospital will result in establishment of rehabilitative treatment relations. Preliminary results of this program demonstrate that patients receiving the interest, attention and continuity of an alcoholism treatment team, make significantly more contacts with the alcoholism clinic, than patients who do not receive special care.

In our recommendation section we will urge that this program be expanded and others developed.

F. Correctional and Law Enforcement Programs.

Those men who are sentenced for drunkenness from the Boston courts are sent either to Deer Island, Suffolk County Jail, or the Massachusetts Correctional Institution at Bridgewater. If a man receives a sentence of less than 30 days he is usually sent to the Suffolk County Jail. If the men receive a 30 day sentence or more, but less than 2 months, they are usually sent to the Deer Island House of Correction. If given a minimum

two month and a maximum six month sentence for drunkenness, he is sent to the Massachusetts Correctional Institution at Bridgewater.

In 1958 there were 1,957 men sentenced to the Boston Charles Street Jail and 163 women. In 1959 there were 2,907 men sentenced to the Boston Charles Street Jail and 233 women. In 1958 there were 842 men sentenced to Deer Island, and in 1959 there were 750 men sentenced to Deer Island (18.)

In 1958 there were 2,284 men sentenced to Bridgewater for drunkenness. Approximately half this number were sentenced from Boston.

In 1959 there were 2,473 men sentenced for drunkenness to Bridgewater. Approximately 50% of these men are sentenced from the Boston courts (17, 18.)

It should also be noted that about 50% of the women sentenced to the Massachusetts Correctional Institution at Framingham are sentenced for drunkenness. A study (23) of the Framingham population has shown however, that approximately 70% of the women sent to that institution have an alcohol problem.

At Deer Island House of Correction and at Suffolk County Jail there are no special programs for the drunkenness offenders. On the other hand at Bridgewater there is a special program.

The Bridgewater institution services the criminally insane, the defective deliquents, the sex deviates and the chronic drunkenness offender. The chronic drunkenness offender is housed in a section designated as the "prison side". For the large bulk of men on the prison side, that is the drunkenness offenders, comprising some 600 men at any one time, the program is essentially a work program. The men are assigned to various jobs within the prison, such as the bakery, the farm, the piggery, etc. However, approximately two years ago a special pilot program was inaugurated (12). About sixty men are on this special pilot program at any one time. Men on this program in addition to their ordinary work activities participate in group therapy, individual counselling, AA meetings, and in group meetings in which they hear speakers from outside the institution such as a clergyman, a social worker from one of the state's alcoholism clinics, a businessman, or the director of the state alcoholism program. They also have available to them library and church facilities as do all of the men. This is a well-rounded program which despite the fact that it suffers from a shortage of personnel, has had a measure of success in starting some men off on the road to rehabilitation. Bridgewater is a key institution in the network of institutions and agencies servicing the drunkenness offender.

In Framingham, for the last several years, in addition to regular program activities available to all of the inmates, some of the alcoholic women have participated in two different kinds

of program. One program involves the staff of the Peter Bent Brigham Alcoholism Clinic. Staff members from this clinic have gone out to Framingham and began individual treatment with these women while they are in the institution, hoping that when their sentence at the institution is terminated they would then continue in treatment on an out-patient basis in the city. This program so far has shown a good deal of success. A second demonstration program is that in which Miss Hilma Unterberger of the Massachusetts Division of Alcoholism has conducted a group therapy program for a number of alcoholic women. At the same time one of the officers of the institution has acted as observer for this group and has been trained to take over and conduct the group herself. The plan is to train several officers in this way so that more inmates can be reached and that the personnel of the institution can conduct the treatment themselves.

G. BOSTON PUBLIC WELFARE DEPARTMENT, HOMELESS MEN SERVICE

Location. 35 Chardon Street, Boston, Massachusetts

Hours open. Monday-Friday 9:00A.M. - 5:00 P.M.
Every night 6:30P.M. - 9:30 P.M.

Service. This section offers financial assistance, referral and counselling for sober male applicants.

Patients receiving more than $52.00 per month in pensions or other support cannot ordinarily be aided. Patients clearly in need of medical attention will be sent to a hospital (usually Boston City Hospital).

General lodging assistance, and breakfast, is given for no more than six nights per month for Boston residents and six nights per year for non-Boston residents.

The Section may offer: (1) a rental deposit for a room, (2) lodging at the Boston Industrial Home, (3) meal tickets, and (4) bus tickets for voluntary admissions to Bridgewater State Farm.

Census. Average requests for assistance per month are 1500, per night 50. Approximately half will be Boston residents, 5% each month will be new cases.

Staff. Total staff consists of 2½-3 professionals and one secretary shared with the employment agent.

Other Programs. In addition to the Homeless Men Section the more traditional public welfare services: medical assistance, OAA, general relief and aid to disabled, are also used for the homeless men, if eligible.

For example, the Public Welfare Program supports 600 patients at Long Island Hospital each year (average cost $4,000 per year each patient).

Impact of Urban Renewal. The impact is already being seen. As the men move from the Scollay Square and West End fringe area, requests for assistance are going down. As a consequence the evening program will probably be moved to the South End. Consideration is also being given for some use of the 5 district offices.

Other. The problem is seen as a multi level governmental and regional responsibility. For the Public Welfare Department to operate effectively it will need socio-legislative engineering including changes in the general relief laws.

H. INDIRECT RESOURCES

Introduction. The following is a list of agencies whose primary focus is not alcoholism, but who sometimes offer service to alcoholics

or their families. These services are mainly used by the broader alcoholic community, but they may sometimes be contacted by the homeless man.

Boston Y.M.C.A.

316 Huntington Avenue, Boston, Massachusetts

Club facilities, including residence, food service, recreational and educational facilities. Assists as it can, through counselling services and general activities and facilities. Provides a meeting place for several AA groups. Men only in residence. Men and women in program. Graduated fee.

The Labor Pool Inc.

153 Arlington Street, Boston, Massachusetts

Has daily unskilled work available each day at 1:00 P.M. Used frequently by homeless men.

Lemuel Shattuck Hospital

170 Morton Street, Jamaica Plain 30, Massachusetts

Chronic disease hospital. Accepts patients with the medical complications of alcoholism. These must be referred on an application signed by a registered physician. Any patient with chronic illness resulting from the excessive use of alcohol may be admitted for diagnosis and treatment. This includes cirrhosis of the liver, nutritional disturbances, and neuropathies. Facilities are not available for psychotics or for patients requiring special security measures, even for a limited time. Regular fee.

Massachusetts Division of Employment Security, Administrative Field Service

88 Broad Street, Boston, Massachusetts

400 Stuart Street, Boston, Massachusetts

Offers assistance in job placement. Will cooperate with agencies in rehabilitation programs.

Massachusetts Tuberculosis and Health League

131 Clarendon Street, Boston, Massachusetts

Coordinating agency for the 25 local tuberculosis associations in Massachusetts. Information available relative to alcoholism, especially for tuberculosis patients. No fee.

Travelers Aid Societies

239 South Station, Boston, Massachusetts

Casework service for travelers. Accepts persons whose immediate problem is alcoholism, but the client should be in a condition to be interviewed. No fee.

III. THE IMPACT OF BOSTON'S RENEWAL PROGRAM

1. Existing Geographic Distribution

The main areas of the city in which the homeless men are located are Scollay Square and the South End. The Skid Row area in the South End is demarcated by Broadway on the North, Northampton St. on the South, Tremont St. on the West, and Harrison Ave. on the East. If one were to outline this area on a street map, the total shape would resemble that of a forearm with a clenched fist.

Information available from the Homeless Men's Service of the Boston Welfare Department indicates that the caseload in the Scollay Square area has decreased in the last five years. From informants in the South End area, we also know that there has been an increase in the homeless men population in this area. As families have been moving out, the homeless men have arrived to replace them. In all likelihood there has been, when we put these two facts together, a movement of the homeless man from the Scollay Square area, as their facilities there have dried up, down into the South End area of the city. The main pocket of the homeless men at the present time is located on Dover Street and the many small streets that feed off this thoroughfare. The men's location in this area is not static, but appears to be steadily moving southward in the direction of Upper Roxbury. If one walks down Washington Street in the shadow of the "El," it is not too difficult to witness the "bottle trail." This bottle trail leads us to the Blackstone Square area and the Blackstone Square Park, where one can find during the day men sleeping on the grass, strolling in the area, and sitting on the park benches. As noted earlier, the

Salvation Army, which has investigated this movement, has already purchased a building in the Blackstone Square area and plans to use it as a drying-out center. Residents and businessmen of the South End area have started to complain about the men's movement into this area. For example, in the housing development residents are now finding drunks lying in their hallways when they leave their buildings in the morning. Because of this recognized movement down toward Blackstone Square, because the men would not be acceptable in the central business district of the city, because the men would also be unacceptable in the Back Bay area, and because the South Boston area is too far away from the kind of area which meets these men's needs, it is not too difficult to predict the direction of the flow of the homeless men should they be pushed out of the South End area by urban renewal and clearance. There does not seem to be any other place to go but southward into Upper Roxbury.

2. Social Impact

As Rubington (9) points out, the homeless men who have been alienated from cultural traditions try to fend for themselves in one way or another. These men band together and express their alienation to society as a part of a pattern of organized behavior. Denied status in respectable society, they develop or seek out a social organization in which a role more suitable to their needs is possible. If that role prescribes drinking as defined on Skid Row, the alienated are quite willing to comply. Failure in their social relations leads to withdrawal and in many cases ultimate dependence on alcohol. The breakdown in rewarding social relations creates for the men a need to search out a new primary group. For the homeless men, and especially the derelict,

pathological drinkers, association with people who have undergone similar experiences compensates for the effects of alienation from society. The fall from status is broken by the knowledge that one is no longer alone. Social support, which the respectable world withdraws, can be had from one's associates on Skid Row with less effort.

If through urban renewal the facilities on which these men are dependent are removed or altered, the men will obviously become more visible to the general public than they are now. If in addition there is pressure on these men to "keep moving," then their primary group structure and support will be disrupted. This will create a grave threat for these men, for it strikes at their very fundamental needs for maintaining their lives. No doubt the men will experience increased anxiety and conflict both of an intrapsychic order and with the community at large. Because of this increased personal strain and because of the increased invisibility, it is likely that without planning there will be an increased number of arrests for drunkenness, court appearances, and commitments to jails for drunkenness. In addition, caseloads of agencies and institutions dealing with the homeless alcoholic will probably increase sharply.

3. Dislocation Alternatives

There are two possible alternatives with regard to relocation of the homeless man in the Skid Row area. One would be to allow the men self-determination, and a second would be a planned program. If self-determination is to take place, the men may scatter into various pockets of the city, or they may all tend to go into a new area and create a new ghetto.

The men no doubt will be moving into those kinds of areas which will permit them to continue their present mode of living. This would mean that they would seek out those areas which could supply them with cheap housing, inexpensive meals, pawnshops, poolrooms, bars, taverns, and similar recreational facilities. If allowed to move into those marginal areas of the city which are attempting to hold back the forces of deterioration, it is likely that the impact of these men in these marginal communities might create a change in the balance of restorative and deteriorative factors and make for a new Skid Row. No matter whether the men self-relocate into various pockets in the city or into a single area of the city, hostility and anxiety will be aroused on the part of the incumbent residents. Such a situation should be avoided and this can be done by following the second alternative to dislocation of the homeless man.

The second alternative is for a planned program for relocation of the homeless man. Broadly conceived this could involve relocation into a single area of the city which itself would have redeveloped new facilities such as single room hotels and small apartment unit facilities. This kind of redevelopment and relocation plan is being carried on in the city of Sacramento (5). There a specific site has been selected which meets the requirement of being in fairly close proximity to the city proper. The site is also of sufficient acreage to provide for immediate development of a one-unit hotel facility which would house some 1000 men and potentially have available

land for the construction of additional facilities which might take care of some four to five thousand more individuals. Another requirement met by the new site location was that it was land relatively clear of major improvements and open to purchase within a period of time corresponding to the displacement of the men from the renewal area. Still other requirements met were that the cost was the lowest available consistent with overall requirements, that it was consistent with zoning requirements, and that it was acceptable both to the community at large and to prospective occupants. The hotel facility in this new area is being constructed by a private developer as a commercial facility. It is estimated that the facility will yield a 10.3% income expressed as a per cent of the equity investment.

It is also possible, instead of confining this population to facilities in one geographic area, to develop smaller facilities which would be scattered throughout the Boston area. These facilities might be planned in accordance with the needs of the different subgroups of the homeless man population which we have described earlier.

It is difficult to say which plan of relocation, a confined area with facilities versus facilities scattered throughout the city, would be more acceptable to the public. In this respect the ideas of Kevin Lynch (24) regarding the community's image of the city might be helpful. There may be certain areas in the public's mind which are blank spots to them, and

it could be that locating either one large facility or scattered facilities into these areas would create the least threat to the community.

This discussion of dislocation alternatives has concentrated mainly on the physical side of relocation, although we have briefly attempted to indicate how the needs of the men would fit in with the dislocation alternatives. Unless plans are made for the meeting and management of the human needs of these men on an over-all basis, discussion of physical relocation is not too meaningful.

As must be apparent by now, the homeless man problem is extremely complex. Plans for physical relocation, if they are not tied into the greater community's plans for rehabilitation of this social problem population, can only lead to one thing -- failure. Therefore, we must also have community planning for the agencies and institutions servicing the Skid Row homeless man population, and it is to this task that we now turn.

IV. OPPORTUNITIES AND PROGRAM PLANNING

1. Opportunities

Skid Rows have been part of every large city for a long time. The complexities of the (physical, the social, and the personal) problems presented by the residents of Skid Row are enormous. Perhaps, because of this complexity, the general community has felt that it would be better to leave well enough alone. Perhaps another reason for the lack of attention by the community to the general problems of Skid Row is related to the moral question. The less stable elements of the Skid Row area of the city, the bums, the Winos, the alcoholics, the derelict, the disorderly, and so on, have by their actions adapted a mode of life which is quite contrary to that of the middle class tradition. In the American culture, where we value highly, orderliness, a sense of responsibility, and achievement, the contrary behavior of the Skid Row resident is seen negatively by the general public. Many people view the Skid Row resident, especially the pathological drinker, as having a condition which is self-induced and self-perpetuating. But these men in fact are very sick individuals. Their debilities range from the physical to the psychological.

Despite the existence of values in the community which are opposed to assisting the sufferers on Skid Row, there also exists in the American value system a desire to help one's less fortunate brethren. This latter value has not prevailed for the residents of Skid Row. Except for the activities of those agencies and institutions described in a previous section, the Skid Row individual has fallen through the network of social

agencies and institutions. With urban renewal in the offing for the Skid Row area and for the South End in general, the community is for the first time really confronted with the opportunity to reassess its value system and to introduce a dynamic, vigorous coordinated program to identify and reduce the problems of the men and women of Skid Row.

With urban renewal the opportunity presents itself not only for restoring the South End community in its appearance but also for restoring the homeless men to decent lives. By careful program planning it should be possible to reduce the revolving door arrest pattern for drunkenness (22) and to rehabilitate a substantial portion of the neglected population of Skid Row.

2. Program Planning

A. The Homeless Man Population as a Whole

The homeless man population consists of many subgroups. As we have previously pointed out one might say that there are two Skid Rows, one which is composed of the elderly, the disabled and infirm, and the resident working man, all of whom are not seriously impaired by drinking problems, and the second which consists of the pathological drinking group.

In the case of the non-drinking Skid Row group it would be necessary to assess the housing, vocational, social, and health needs of the men. Perhaps this can be done through the development of a screening and processing center which we will also recommend for the pathological drinking subgroup. These men should be cared for in the kind of housing and institutional facilities which are now available for the more or less indigent and elderly individual.

The conclusions and recommendations of some of the other background papers on public health, the aged, and recreational and leisure time activities should also be directed to these subgroups of homeless men.

B. The Pathological Drinker

The problem drinkers of Skid Row are in need of assistance of many kinds, ranging from their basic needs for housing, clothing, and food to their medical, psychological and social needs. In programming for this population of men it is necessary to meet all of these.

In a general way, a network of community agencies and services must provide for an aggregation of needs. To begin with somewhere in the agency network there must be opportunity for these men to receive assistance in the necessities of life: food, shelter and medical care. There is much that can be done in this respect. The men should not be compelled to beg, panhandle, steal or pray for a meal or shelter. Many of the facilities in which the men live are lacking in heat and frequently they must find other places, especially in the winter time, to get warm. Therefore, many of them will go into the bars sometimes not so much to drink but just to get the warmth. Also many of the places in which they live are lacking in facilities such as lobbies where men might relax, read, congregate and share in a socially interactive way with other men. Again the bars fulfill these needs.

> As a more practical and humane substitute for the bar for purposes of warmth and companionship, we recommend that there be some form of temporary aid stations sprinkled throughout the areas in which these men live. These first aid stations should be open and be very simply staffed by a general helper and a social worker. They would be a place in which a man can soak his feet (they have many foot problems), in which he can lie down and rest if he wishes, and in which he can discuss his problems with a trained individual if he so desires.

Another basic problem with which these men are confronted is the effects of acute toxicity. At the present time, even though some help is available through emergency wards of our main hospitals in Boston, particulary the Massachusetts General Hospital and the Boston City Hospital, what is offered is simply not enough. An injection of vitamins or a sedative or a tranquilizer followed by discharge into the street does not begin to take care of the need of the intoxicated individual.

> What is needed is a hospital ward properly staffed by personnel with a positive attitude toward the alcoholic, and which would provide very short term care for a few days until toxicity is over.
>
> We urge that a 30-40 bed facility be built on the grounds of the Boston City Hospital for this purpose. In addition it should serve as a major diagnostic and screening center with outpatient facilities for long term care.

In short, on this basic level of care we are mainly concerned that some community agencies will cope with the survival needs of the men in as humanitarian a way as possible. At the same time these services will be alert to the possibilities of recruiting the more highly motivated individual who can use rehabilitation services.

At the next level of rehabilitation it is necessary to have some facilities which will provide housing for these men. One of the outstanding problems in the social and personal rehabilitation of these men is the need for temporary housing while the individual is being treated by an agency, e.g. an alcoholism clinic. Unfortunately each of the institutions or agencies now available have their own hours for admission, which frequently do not correspond to the time when an individual is in need of obtaining a bed. Because of this the tenuous link between the patient and the treatment personnel is often broken because the man is housed in those kind of facilities where there exist factors pulling him away from the offered treatment.

> There is need for two different facilities with two different types of service. One such facility should be of the boarding house type with decent accommodations. This kind of boarding house might be run on a commercial basis by, for example, a recovered alcoholic who would be familiar with the problems of the men and who would be supportive of the man's rehabilitation efforts.
>
> Another type of facility that is necessary is a half-way house (11). A half-way house is a small facility providing room and board for approximately thirty men sharing a common problem such as alcoholism. The half-way house environment can be characterized as a group living experience which reconstitutes the protective and supportive elements of a good family, while encouraging and providing opportunities for independent growth.

It should be remembered that alcoholics and inveterate excessive drinkers have suffered a breakdown in their ability to get along with other people. They tend to be immature individuals whose main problem is controlling drinking behavior that is disapproved by

others. In the context of the therapeutic milieu of the half-way house they are helped to substitute their troublesome patterns of behavior with more appropriate modes of coping with the environment. Such a half-way house should be professionally staffed. It should provide opportunities for group and individual therapy, religious and vocational counselling, AA meetings, and an opportunity for group living in a semi-protective environment, while the man is working and paying rent.

After a period of time (approximately 3-6 months) the man would be expected to graduate into the community.

> To do so an opportunity always should be available for these men to use the facilities of the half-way house program in the evening.

This has two advantages. First, it satisfies the needs of the working individual who still is not integrated into the general community. And, second, the presence of these men within the half-way house serves as a model for the new men going through the program who can identify with them and can be encouraged by their success.

What we have described to this point are the graded needs of these men, from the most basic to the furthest advanced. The salient feature of these graded steps is that there is provision to move the man from step to step and from agency to agency on a passage out of Skid Row. To do this, however, it is absolutely essential that there be continuous communication between all of the agencies involved in servicing the problem drinker, and this brings us to our next recommendation.

One of the things which we have found in our survey of the various agencies and institutions concerned with the homeless man

and the problem drinker is that for the most part they see the problem not on a general community level but mostly from their own point of view. This is not meant as a criticism of any individual agency, for these agencies are generally so busy with what they are doing that they do not have the time and are unable to see the problem from a larger perspective.

> Therefore, as an immediate priority item an authoritative planning body should be established which will concern itself exclusively with this special problem. In order to give it sufficient status and authority, it probably should be offically sponsored by the Mayor of the City of Boston, perhaps in conjunction with the Governor. Its function would be to develop and implement a plan of action on a continuing basis.
>
> Available to this committee should be the services of a professional staff with a director which would work exclusively with all aspects of the problem and with all agencies.

This committee staff should be affiliated with an existing agency concerned with overall planning for proper supervision and control. Three possibilities occur: (1) they could be attached to the Division of Alcoholism, State Department of Public Health, the agency charged by the Massachusetts Legislature with overall planning in alcoholism, (2) they could be established as a special group in the United Community Services of Boston and (3) be given permanent status as part of the Boston Community Development Program. Whichever group serves as parent, the others would necessarily be closely allied to it.

Agencies represented on the Committee should include the following (and probably others):

Boston Health, Welfare, Police Departments and Institutions.
Boston Community Development Program.
Urban Renewal Authority.
Massachusetts Departments of Public Health, Mental Health, Welfare, Correction, Rehabilitation Commission.
Division of Employment Security, Commissioner of Probation.
State Labor Council, AFL - CIO.
Boston Chamber of Commerce.
United Community Services.
Boston Tuberculosis & Health Association.
The Salvation Army.
Morgan Memorial.
A Municipal Court judge, and the alcoholism clinics.
The Missions.

The Committee should be free to accept or reject any or all of the recommendations contained in this report.

It should develop a priority program designed to provide facilities and personnel in order of importance.

It should evaluate existing legislative and administrative procedures. It should act to bring them into conformance with the Plan.

It should determine the cost of construction, renovation, and personnel necessary to activate, expand, or alter existing programs.

It should initiate action to secure necessary financial support for programs given highest priority.

It should actively discourage effects misguided or poorly directed.

Viewing the Skid Row problem in its broadest perspective, it is essential to plan for the best use of existing and newly recommended facilities and to plan for relocating the men into new housing.

> We, therefore, recommend the establishment of screening and processing center, perhaps the same center which would attend to the needs of the entire homeless men population. The center should be staffed by individuals trained in the medical, psychiatric, and social services.

These teams would assess the problems and needs of the men, and in cooperation with the executive director in charge of the Skid Row program and the network of social agencies would plan for appropriate placements. Some individuals may have to go directly to hospitals to obtain needed medical care. Other individuals may be directly relocated into other existing communities in small rented rooms or apartments. Other individuals may have to be hospitalized in mental institutions. Still other individuals may need the kinds of homes available for the elderly. Still other individuals with chronic physical disorders may require the care available in such an institution as the Long Island Hospital. Still other individuals might be able to benefit from the program for alcoholics at the Long Island Hospital, or at the half-way house if it is provided, or at the out-patient alcoholism clinics. There are any number of possibilities. This kind of screening and processing center has also been recommended by the Philadelphia study group (4).

Although the Scandinavian countries have used their courts as a major case finding, diagnostic, treatment and referral center

for alcoholics, American experience is limited.

One such American experiment occurred in the District Court of South Norfolk in Stoughton, Massachusetts in 1950, under the direction of Dr. Martha Brunner-Orne. The objective was to substitute treatment and education for punishment and confinement. The approach was threefold: physical, emotional and environmental. The clinic met once a week. After an initial interview a physical examination and laboratory tests were given; vitamins, sedation and in selected cases, Antabuse was used. The emphasis was placed on arousing the patient's interest in treatment and in developing a relationship.

A 1951 evaluation of the program is as follows: Patients responded well to psychotherapy (group therapy). Evening meetings were instituted with discussions and educational films. The clinic helped patients to find jobs if necessary. Patients continued to come to the clinic after their attendance ceased to be compulsory.

Of the first 32 people referred by the court, 16 were helped. Of a total of 38 patients (some voluntary), 22 were helped, 8 were failure and 8 were uncertain.

The significant finding is that alcoholics can be helped in a court setting even if he first attends the clinic under coercion.

> We strongly urge that a demonstration court clinic for alcoholics be established in either the Roxbury or Boston Municipal Court. Because of the multitude of alcoholics passing through the courts daily, they offer an ideal locale for a diagnostic, treatment and referral center. The Division of Legal Medicine, State Department of Mental Health along with the courts and their probation service would be the significant agencies here.

For many of the men who do not work or who are unable to work

there is nothing available to them to participate in during the day.

> We recommend a day center program that might be modeled on the day hospital program (25). If the men had available to them a place to go for companionship and recreational facilities, a place in which they would be accepted, this could provide a good plan for keeping them off the street. The day center should also have staff available to these men for consultation and counselling. Therefore, such a center would also be one of the network of social agencies which could start a man on the road up and out of Skid Row.

No matter how much planning we may do from our ivory towers, if the men on Skid Row are not interested in what is offered by the network of agencies, then our efforts are fruitless. This fact was recognized by the planners in Philadelphia. They recommended a study phase in which research and clinical workers would spend time with these men in trying to develop techniques for communicating with them and for motivating them to go along with plans made. Obviously, the most ideal aim we can hope for is that the program will benefit both the man himself and the community at large. In the Philadelphia study(4) there were no specific recommendations made with respect to motivating the men for planning for their future in relocating.

> At the present time experience in another area of endeavor suggests to us the possibility of making a specific recommendation in this regard. For the past several years many college students at the Phillips Brooks House, Harvard University, have volunteered to work with extremely regressed and backward mental patients at mental hospitals. In their efforts they have learned a great deal and have achieved a reasonable degree of success with patients for whom all hope had been forsaken. There is no reason why we cannot expect equal success with the habitual problem drinkers of Skid Row through the efforts of these or other students. Personal communication with David Kantor (26), who has directed these students efforts in the mental hospitals for

> several years, has encouraged us with the potentialities of this idea. Skid Row as Kantor says is an "institution within walls" and would be a logical extension for pursuing college student activities. Such activities could range from obtaining voluntary help in teaching courses in the Salvation Army to street corner work by the students with Wino groups in a manner resembling street corner work with deliquent groups. The students, under careful supervision might very well be able to reach many of these men and motivate them toward planning their lives in a way which would be beneficial to themselves and to the community.

Of course in a general way many of the needed services on the part of the Skid Row alcoholic will have to be fulfilled by the existing agencies and institutions.

> To do this, many of the agencies will require additional strengthening and some of them will also require an alteration in their efforts.

Perhaps some of these alterations will come about through the mutual coordination and cooperation in a formal planning body. For only then will the agencies be able to assess the needs of their fellow agencies, and see in what ways they may be able to fulfill these needs.

While we are not prepared to make specific legislative recommendations there are a number of questions which can probably be corrected only through legislative action.

> The archaic nature of present settlement laws are most clearly evident in their inability to cope with the homeless alcoholic. They need repeal or at least revision.

Because the law enforcement officials and institutions make up the major caretakers and caretaking institutions, we do not suggest that drunkenness no longer be a crime. Until adequate substitutes can be secured any such recommendation would

be not only unrealistic and unworkable but would work to the detriment of the homeless alcoholic.

> Nevertheless the removal of the crime of drunkenness from our books should be a long range objective.

> We do urge that provisions be made for indeterminate sentences and that special rehabilitation facilities be established in correctional institutions.

(See the report on the M.C.I., Bridgewater by the Office of the Commissioner on Alcoholism for specific suggestions.)

> We urge that General Relief provisions be ammended to provide for State and/or Federal assistance.

There is no question that there are men on Skid Row who are permanently disabled with respect to functioning in the community.

> We would raise the moral question of whether it would be of greater benefit both to these men and to the community if they were provided with a facility such as a camp or an institution such as Camp LaGuardia in New York which would enable them to live out their lives in a way free of their present squalor. Or would this be depriving them of their individual liberty?

V. - Summary of Recommendations

Throughout the text of our report a number of recommendations have been made. For quick reference we have summarized them below.

We recognize that our plan should be considered a long range one; we do not expect that solutions will happen overnight. Some, however, can be adopted quickly. For these we urge immediate action.

We recommend the following:

(1) An authoritative planning body.

(2) A professional staff available to the planning body which should be hired by one of the overall planning agencies to work exclusively on all aspects and with all agencies.

(3) Diagnostic and evaluative centers, possibly in conjunction with a new court alcoholism clinic, a special inpatient facility for alcoholics at Boston City Hospital and for the emergency ward of the Massachusetts General Hospital.

(4) Hospital beds for treatment of acute withdrawal symptoms, perhaps at the Boston City Hospital (as noted above.)

(5) Half-Way Houses.

(6) Permanent residential facilities, perhaps farm-like settings, for those not presently rehabilitable.

(7) Boarding homes with understanding, skillful proprietors.

(8) Facilities serving as a kind of "first aid" station.

(9) Day and evening centers with recreational and other programs.

(10) Existing agencies should be strengthened.

(11) A demonstration program using college students.

(12) New legislation.

(13) Research to be supported as an ongoing process.

VI. - Conclusions

This report represents an attempt to develop a basis for planning and action to deal effectively with the "homeless alcoholic" recognizing that urban renewal and redevelopment will necessarily alter their existing network of problem solving devices.

Despite recent advances in the treatment and programming for the alcoholic, little progress has been made in providing appropriate facilities and treatment programs for the homeless skid-row alcoholic. In a sense the comprehensiveness of Boston's urban renewal plan will soon force on the social planners of Boston a problem which they have long avoided -- what to do for these men.

Our purpose then, as a result of a request by the Boston Community Development Program, was to take the first step in filling this gap. Essentially we have tried to describe the dimensions of the problem, some of the major resources which we used to cope with it, the gaps and finally the steps necessary to deal effectively with it. In a sense our report should serve as a preliminary planning document. We stress the preliminary aspect for we fully recognize the many limitations in our document, some due to the speed with which it had to be prepared and some due to the complexity of the problem.

No panacea for the Skid Row problem is available with our present knowledge. Nevertheless, we believe that by taking some or all of the steps recommended, the Skid Row problem and the relocation aspects associated with it can be attacked with a good deal of success. Although, not all of the homeless men and the chronic alcoholic subgroup within this population will make it out of Skid Row, the least we can do

is increase the opportunities for a vast number of more men to do so, and for those men who are unable to make it, we can provide efforts which are more humanitarian.

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A P P E N D I X

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Acknowledgments and Apologies

During the course of writing this report we found many of the studies and papers listed in the references to be invaluable resources. At several points, especially in the discussion of Skid Row subgroups, we liberally used the material of these reports, always citing the general reference source, but not always providing quotation marks or specific page references. For this we apologize and hope that the authors involved will understand that this report had to be prepared within a very short time period, one month from start to finish.

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Finally a word is in order about the distribution of labor in preparing this report. In each stage from the assessment of the network of social agencies to the writing of the final manuscript both authors were equally involved and share responsibility for the descriptions and recommendations made.

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